



West End
Veterinary Clinic

West End Veterinary Clinic
3412 Pump Rd.
Henrico, VA 23233
804-360-0111

Client Registration

{CURRENTDATE[SHORT]}

Owner Information:

Owner Name: {FULLNAME}
Address: {ADDRESS1} {ADDRESS2}
{CITY} {STATE} {POSTALCODE}
Phone: {PHONENUMBER}
Email: {EMAILADDRESS}

Patient Information	Pet #1	Pet #2	Pet #3
Name	_____	_____	_____
Breed/Color	_____	_____	_____
Date of Birth/Age	_____	_____	_____
Sex/ Spayed or Neutered?	_____	_____	_____
Previous Illnesses/surgeries	_____	_____	_____
Allergies to vaccinations/ medications	_____	_____	_____
Special Diet	_____	_____	_____
Rabies Vaccine Date	_____	_____	_____
Distemper/Lepto Vaccine Date	_____	_____	_____
Bordetella Vaccine Date	_____	_____	_____
Lyme Vaccine Date	_____	_____	_____
Fecal (Stool Sample) Date	_____	_____	_____
Feline Leukemia Vaccine Date	_____	_____	_____
FVRCP (Feline Distemper) Date	_____	_____	_____
Heartworm Test/Prevention	_____	_____	_____

FOR FELINES ONLY: are they _____ indoor _____ outdoor _____ both

Do you board your pet? _____ yes _____ no if yes, where? _____

Any additional information you would like for us to know about your pet? (i.e. dislikes men, separation anxiety, vaccination reactions, etc.)

Would you like to be present during treatment of your pet(s)? _____ yes _____ no

How did you hear about our clinic? _____ drove by _____ online review _____ website
_____ personal referral (whom may we thank?) _____

**PROFESSIONAL FEES ARE TO BE PAID AT THE TIME SERVICES ARE RENDERED.
PLEASE CHECK YOUR PREFERRED METHOD OF PAYMENT BELOW.**

_____ Cash _____ Credit Card _____ Care Credit _____ Check

We will gladly prepare a written estimate if you desire. Please ask the vet assistant or doctor.

In the event your account is turned over to a collection agency or an attorney, you will be responsible for all collection cost and attorney fees up to 33%

Please initial the follow statements:

_____ **For valuable consideration received, I hereby grant West End Veterinary Clinic, and it's representatives and assigns, the irrevocable and unrestricted right to use and publish photographs or me or my pets, or in which we may be included, for editorial trade, advertising, and any other purpose and in any manner and medium, and to alter the same without restriction and release from them all claims and liability relating to said photograph.**

_____ **I am responsible and agree to pay in full the total charges for services rendered at the time of discharge and any fees incurred for collection of said charges. I understand that the fees are based on treatment deemed necessary at the time of exam, treatment, or admission, and that the estimate fee may be raised or lowered by the administration of treatment, medication, surgery, or diagnostic tests. In the event that you do not pay the total charges for services rendered as agreed, you shall be responsible for reasonable attorney's fees (33.3%), costs of collection, late fees, and interest at 6% from the date of default (30 days past due)**

_____ **I understand that will be a \$30 fee applied to my account in the event that I miss an appointment or fail to cancel an appointment with less than 24 hours' notice.**

_____ **I understand that there will be a \$100 non-refundable deposit for all surgery appointments; this deposit will be applied to the cost of surgery if performed when scheduled.**

Authorized person(s) allowed to present pet(s) for treatment other than the owner:

Name _____

Relationship to owner _____

Phone number _____

Signature _____

Printed Name _____

Date _____